Mental Welfare Commission for Scotland

Report on announced visit to: New Craigs Hospital, Willows Ward, Leachkin Road, Inverness, IV3 8NP

Date of visit: 22 May 2024

Where we visited

Willows Ward provides assessment and treatment for six adults who have an intellectual disability, mental health problems, and behavioural issues. There were five individuals in the ward at the time of our visit.

We last visited this service in April 2023 and made recommendations on care plans, having meaningful activities on and off-ward, and ensuring there is an appropriate environment for the needs of this complex group of patients.

The response we received from the service was that procedures have been introduced to bring about improvements in the areas highlighted in the report, including a masterplan to look at future accommodation when the current contract with the private provider expires in 2025.

As at the time of our last visit to the service, we also wanted to find out if there had been progress made towards the discharge of individuals, who are currently awaiting placements being agreed and/or staffed.

Who we met with

We met with, and reviewed the care of five people, two of whom we met with in person and three whose files we reviewed.

We spoke with the hospital manager, associate nursing director, the senior charge nurse (SCN), the service lead, and consultant psychiatrist.

Commission visitors

Dougie Seath, nursing officer

Paul McQuire, nursing officer

What people told us and what we found

Care, treatment, support and participation

When we last visited the service, we found examples of detailed and person-centred care plans that addressed the full range of care for mental health, physical health, as well as the general health and wellbeing of the individual. There was less evidence of patient involvement on file.

On this occasion, we were pleased to find that care plans continued to be detailed and person-centred, and they evidenced patient involvement; we were also pleased to find easy read versions of the care plans that were used in patient discussions. Reviews of personal support plans were largely carried out in a timely manner.

It was good to see that discharge care plans were in place where appropriate. We also found comprehensive information contained in one-to-one discussions with named nurses. Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed.

We saw that physical health care needs were being addressed by the GP and followed up appropriately by the learning disability service.

We found occupational therapy (OT) notes, psychology assessments and formulations that were based on a detailed, personalised approach. There was regular input from speech and language therapy (SLT), that provided continued use of effective communication strategies to engage individuals and promote participation.

At the time of our visit, three people were considered to be delayed discharges, with one other person who had recently transferred to a more specialised resource in England. The issue causing the delays relates to the lack of support staff available to provide adequate packages of care in Highland.

Multidisciplinary team (MDT)

Willows Ward is staffed by both learning disability and mental health nurses. We were told that there were some staffing vacancies across the service and that there continued to be a recruitment drive to fill vacant posts. Only five of the 11 registered nurses were learning disability specialists. Three nurses had recently been recruited from abroad with mixed success due to their lack of specialist training in this area.

Staffing challenges were acknowledged by managers who continue to be proactive in their efforts to recruit. We recognised that this is an issue nationally, and specifically with learning disability nurses. We heard that where shortages exist, and when possible, the wards continued to use regular bank and agency staff to promote consistency and maintain relationships that have been established, in order to enhance the quality of care provided to the patients. We were told that once nurse staffing are in post, there had been a good retention rate.

There was only one full time consultant psychiatrist in post, assisted by a specialty doctor who, unfortunately, was about to leave. There was sessional input from psychology,

occupational therapy (OT), speech and language therapy, GP, social work, dietetics, and pharmacy. We were pleased to see the involvement of the above disciplines in multidisciplinary team (MDT) meetings and that, where appropriate, families were invited to attend via online meetings platforms or in person. It was also good to see that patients were given the choice to attend.

The MDT meetings were augmented by core group meetings, where ward staff meet to update care plans and discuss options with patients outwith the full MDT meeting.

We were very concerned that the service has only one full-time consultant psychiatrist whose remit is the whole of north Highland, and covers both the in-patient service and all community patients. This does not seem sustainable in the longer term.

Recommendation 1:
The Commission would like an early update on what is being done to review the safety and clinical efficacy of the level of consultant psychiatry support to patients in the learning disability service.

Use of mental health and incapacity legislation

Everyone in Willows Ward was detained under the under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act). Authorising treatment certificates (T3) under the Mental Health Act were present and available in case records where required. Where people were subject to guardianship under the Adults with Incapacity (Scotland) Act, 2000 (AWI Act), there was a copy of this in their files.

We found the monitoring of legislative matters to be exemplary and statutory forms in both Mental Health and AWI Act to be fully compliant with requirements. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found section 47 certificates were present with attached treatment plans in all cases.

Rights and restrictions

Willows Ward continues to operate a locked door, commensurate with the level of risk identified with the group of patients.

Sections 281 to 286 of the Mental Health Act set out a framework where restrictions are required to were in place. Where an individual is a specified person in relation to this, and where restrictions are introduced, it is important that the principle of least restriction is applied. Where this was required, we found reasoned opinions in place.

Our specified persons good practice guidance is available on our website.

We were also pleased to see that the Use of Seclusion guidance was in use, and that care plans are reviewed regularly to ensure the least restrictive option is maintained.

When we are reviewing individual files, we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under sections 274 and 276 of the

Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment.

Activity and occupation

The ward had dedicated OT input that provided assessment and focused mainly one-to-one activities. The OT staff continued to carry out assessments as part of each person's discharge planning, supporting their re-integration back to the community. We saw that there were weekly planners in place and people told us about their activities.

Individuals told us that they enjoyed being out in the community. We noted that there was clear recording of activities that were taking place and that there was a regular review of these with individuals. We heard about the efforts of nursing staff to ensure there was always activity available on the unit, and that escorts were provided for walks around the grounds or into town.

The physical environment

As commented on in our report of 2023, the ward environment remains unsuitable for this group of patients. There was insufficient quiet space, difficulty in providing activities without encroaching on the available space for others and generally the ward felt cramped, with little alternative for people but to stay in their bedrooms much of the time. There is enclosed garden space, but this is uninspiring, unfit for purpose and has access and surface difficulties for some individuals.

The acoustics and lighting of the ward are not conducive to the care of patients with Autistic Spectrum Disorder and the appearance is, in the main, stark and clinical, other than where staff have involved individuals in designing murals. It is also difficult to maintain privacy in public areas, due to lack of screening from nearby paths and roads. There is insufficient space for clinical meetings and the distance from the main hospital means that conducting these elsewhere is impractical.

Not all rooms are en-suite, and the staff toilet is unacceptably located in the patient dining area. Also, there are no facilities for people to prepare and cook meals, as part of their rehabilitation for discharge.

We were assured that there was a review being undertaken by senior managers on the suitability of accommodation in Willows Ward, and that we would be notified of any decision taken when this is complete.

Recommendation 2:
Managers should ensure that the current review results in the provision of an appropriate environment for the needs of this complex group of individuals with suitable space (both indoors and outdoors) to allow nurses to keep patients safe and provide therapeutic care.

Summary of recommendations

Recommendation 1:
The Commission would like an early update on what is being done to review the safety and clinical efficacy of the level of consultant psychiatry support to patients in the learning disability service.

Recommendation 2:
Managers should ensure that the current review results in the provision of an appropriate environment for the needs of this complex group of individuals with suitable space (both indoors and outdoors) to allow nurses to keep patients safe and provide therapeutic care.

Good practice

We were impressed with the efficacy of maintaining Mental Health Act and AWI Act forms in Willows Ward. Managers should look to replicate the protocol used in the ward for monitoring legislative matters in all other areas of the hospital.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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